

**INSTRUCTIONS FOR DATE OF SERVICE / UNIFORM BILLING DOCUMENT  
(Long Form)**

**This form must be used for Respite.**

- 1. PROVIDER:** Provider name as contracted with DES/DDD.
- 2. FEDERAL EMPLOYER IDENTIFICATION/SOCIAL SECURITY NUMBER:** Provider's Federal Employer Identification Social Security Number.
- 3. ADDRESS:** Provider address.
- 4. GROUP AHCCCS ID:** The Provider's group AHCCCS ID number.
- 5. INDIVIDUAL PROVIDER AHCCCS ID:** The individual provider/therapist's AHCCCS ID number. Not necessary for services not subject to Third Party Liability (TPL) billing.
- 6. CONTRACT NUMBER:** The Provider's contract number. This contract # must correspond to the fiscal year that bills are submitted.
- 7. SERVICE:** The service that is being billed.
- 8. MONTH/YEAR OF SERVICE:** The month and the year that is being billed.
- 9. ADDITIONAL UNITS:** You may bill extra units of service in addition to those for which you have already been paid as long as they are a legitimate claim. This is done by putting an "X" in this column for the appropriate consumer. You cannot use this column if you billed at the wrong rate or for any other purposes.
- 10. PROVIDER LOCATION:** Two letter providers **Location Site Code** where service was delivered. (e.g. AA, AB, etc.)
- 11. CONSUMER NAME**
- 12. CONSUMER ASSIST ID:** This is the ASSISTS consumer identification number assigned by the ADES/DDD.
- 13. INDIVIDUAL DATES OF SERVICE:** Do not fill in with an X. Enter the **number** of units delivered for each specific date of service. If daily unit, enter 1 for each service delivery date; if hourly unit, enter number of service hours delivered each day.
- 14. POS:** The Place of Service code. The two-digit code indicates the **type of setting** where the service was delivered.

**PLACE OF SERVICE:**

<b>TWO DIGIT CODE</b>	<b>TYPE OF SETTING</b>
11	Office
12	Patient's Residence (home, ADH, CDH, group home, IDLA, etc)
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
54	Intermediate Care Facility/Mentally Retarded
56	Psychiatric Residential Treatment Center
99	Other Unlisted Facility (e.g. park, transportation, store, etc)

**15. DELIVERED UNITS:** Enter the number of units delivered.

**16. ABSENT Units:** This in not functional at this time.

**16a. NO SHOWS:** **Therapy No Shows** have to be billed as a one-half unit at the full rate. For all No Shows, use column 16 and input "NS". Use a separate line for all No Shows and put in 0.5 units in the appropriate date box. All other services must be entered as delivered units.

**Therapy Waivers:** *If you are changing your name or your Provider I.D. you must contact Erika Verley at 602-542-6885 or email at EVerley@azdes.gov so you waivers can be switched to the new number. Otherwise, all payments will be denied for these waivers.*

**17. TOTAL UNITS:** Sum of Column 15 and Column 16.

**18. SERVICE CODE:** The 3-digit service code that corresponds to the service being billed under #7 above.

**19. TPL CODE:** For TPL Billing ONLY: Third Party Liability Code. NOTE: For all consumers having insurance, you must include an Explanation of Benefits (EOB) that corresponds to the service and date delivered or a waiver.

**20. TPL AMOUNT:** For TPL Billing ONLY: Third Party Liability amount paid by insurance companies. The third Party Liability Amount that is required is the amount you receive - but only up to the maximum of your contracted rate. For example: if the contracted rate is \$70 and the amount you are paid TPL is \$100, enter \$70 (your contracted rate) in column 20 and the amount to bill the Division is \$0.00. If the contracted rate is \$70 and the amount you are paid TPL is \$50, enter \$50 in column 20 and the amount to bill the Division is \$20.00.

**21. RATE.** Published Rate for service delivery or contracted rate for non-557 services.

**22. TOTAL (Row):** Enter the total dollar amount billed. (billed units/hours x rate = total amount) less any TPL if applicable.

**23. PAGE TOTAL.** Total all of column 22.

**\*PREPARER'S and PROVIDER'S SIGNATURES:** The signature of the individual preparing this invoice.

**\*DATE:** The date on which the preparer signed the invoice.

**NOTE: Uniform Billing Documents will only be accepted after the last date of service for the month billed.**

**DO NOT SHRINK DOWN TO 8.5 X 11 SIZE PAPER**